DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2678 (02/2007)

COMMUNITY RELOCATION INITIATIVE
INITIAL INFORMATION AND FUNDING ESTIMATE

Completion of this form is voluntary. If not completed, the request cannot be processed. The personally identifiable information is being collected to process **potential** program eligibility. Completed forms will only be accessed by staff processing the request.

Name – Applicant		County Applying
Date of Birth / /	Medicaid Number	Name of Nursing Home

Date of Admission to Nursing Home / /	Date of Planned Relocation/Discharge / /	Is the Nursing Home Closing or Downsizing? ☐ Yes ☐ No

Document why this person's nursing home stay is expected to be long term

Proposed New Living Arrangement	Estimate of the person's **daily waiver** cost (Do not include room and board, cost share or one time waiver costs.)

This cost **includes** the following estimated **daily** amounts:

Supportive Home Care	CBRF Service Per diem	Transportation
Adult Day Care	Care management	Other

One time waiver costs:

Adaptive Aids	Waiver Allowable Home Modifications	Room and board costs in substitute care setting

Estimate of the daily **Medicaid card** services person will need (hours/day; times/week):

MA Personal Care	Home Health (RN / Therapies)

Other Known, e.g., Transportation., DME, DMS

Will this person receive **SSI** upon return to the community?	☐ Yes	☐ No
Will this person access the SSI Exceptional Expense (**SSI-E**) benefit?	☐ Yes	☐ No
Will **one time funding** be needed for start-up costs (clothing, groceries) not covered by CIP II SPC 106.03 or 604.04?	☐ Yes	☐ No

Explain cost and items

Amount of person's income:

SIGNATURE – Care Manager		Name – Care Manager (**Print**)	Date Signed / /
Telephone Number	Fax Number	E-Mail Address	

Fax completed form to Bureau of Long-Term Support/Community Relocation Initiative at 608-267-2913

For Bureau of Long-Term Support use

☐ **Estimate** not able to be approved: ☐ no Medicaid data available ☐ BLTS will hold as pending

☐ **Estimate** approved. Develop and submit waiver application packet to TMG for **FINAL** approval of CRI plan and funding.

Estimate approved by BLTS on: / /	Total Estimate Amount Approved:	Estimate approval faxed to county on: / /